STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155707	A. BUILDING -- B. WING	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLAGE	1350 W MAIN ST BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/02/23 Facility Number: 000280 Provider Number: 155707 AIM Number: 100274540 At this Emergency Preparedness survey, Swiss Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 128 and had a census of 84 at the time of this survey. Quality Review completed on 03/07/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/02/2023 Facility Number: 000280 Provider Number: 155707 AIM Number: 100274540 At this Life Safety Code survey, Swiss Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sierra Saylor	VP of Operations	03/24/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident rooms. The facility has a capacity of 128 and had a census of 84 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/07/23			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or	K 0345	K345- **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No individual resident was	04/21/2023

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	more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Director of Facilities on 03/02/23 at 11:35 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted on 09/27/22. Based on interview at the time of records review, the Director of Facilities stated a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection was not conducted. This finding was reviewed with the V.P. of Operations and Director of Facilities at the exit conference. 3.1-19(b)		identified in this alleged deficiency. Visual inspection audit created and will be completed semiannually. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents were identified. All residents had potential to be affected. An audit was created to perform the visual inspections semiannually. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Director of Facilities educated on completion of this visual inspection. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the VP of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan**	

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			of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. By April 21, 2023, the systemic changes for this deficiency will be completed.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a			

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	program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 2 of 2 facility diesel powered generators. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review with the Director of Facilities on 03/02/23 at 1:30 p.m., no documentation of an annual fuel quality test for the diesel generators was available for review. Based on interview at the time of records review, the Director of Facilities stated they did have the generator fuel tested but was unable to find the documentation at the time of this survey. This finding was reviewed with the V.P. of	K 0918	K918- **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No individual resident was identified in this alleged deficiency. On March 15, 2023, Clean Fuels came and cleaned both generator fuel tanks. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents were identified. All residents had potential to be affected. On March 15, 2023, Clean Fuels came and cleaned both generator fuel tanks. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Director of Facilities educated on	04/21/2023

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	Operations and Director of Facilities at the exit conference. 3.1-19(b)		completion of annual generator fuel quality testing. Fuel quality testing was completed on March 15, 2023 and facility is awaiting results. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the VP of Operations. The Directors of Facilities will continue ongoing monitoring and scheduling of testing. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By April 21, 2023, the systemic changes for this deficiency will be completed.	